State of California
Office of Emergency Services

MEDICAL REPORT:
SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION

OES 900

For more information or assistance in completing the OES 900, please contact
University of California, Davis California Medical Training Center at:
(916) 734-414 or www.calmtc.org

This form is available on the following website:
http://www.oes.ca.gov

MEDICAL REPORT: SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION
State of California
Office of Emergency Services
OES 900

Confidential Document: Restricted Release | **Patient Identification:** | **Date:**

A. GENERAL INFORMATION

☐ See Patient Label/Registration Face Sheet

1. Name of Medical Facility Where Exam Performed	Facility Address	2. Date of Exam	Time of Exam

3. Patient's Last Name	First Name	M.I.	Telephone	Cell Phone

4. Street Address	City	County	State	Zip Code

5. Age	Date of Birth	Gender ☐ Female ☐ Male	Ethnicity

6. Interpreter Used: ☐ No ☐ Yes Language Used: _____

Name of Interpreter: _____ Telephone: _____

Affiliation of interpreter: ☐ Facility Interpreting Services

☐ Contracted Agency, specify: _____

☐ Family ☐ Friend ☐ Other, specify: _____

7. Name of Child's Caregiver ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____ | **Gender** ☐ Female ☐ Male | **Telephone** (w) (h) (c)

Street Address	City	County	State	Zip Code

8. Name of Child's Caregiver ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____ | **Gender** ☐ Female ☐ Male | **Telephone** (w) (h) (c)

Street Address	City	County	State	Zip Code

9. Name(s) of Siblings	Gender	Age	DOB	Name(s) of Siblings	Gender	Age	DOB
	M F				M F		
	M F				M F		

B. MANDATORY REPORTING FOR SUSPECTED CHILD ABUSE AND NEGLECT

Mandatory Child Abuse/Neglect Report made to both Law Enforcement and CPS Agencies (Pursuant to Penal Code §11166):

	Name of Agency	Telephone	Date
☐ Law Enforcement ☐ Telephone Report ☐ Written Report Submitted Name of Person Taking Report:			
☐ Child Protective Services ☐ Telephone Report ☐ Written Report Submitted Name of Person Taking Report:			

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

Name	ID Number	Agency	☐ Unknown
Child Protective Services			
and/or			
Law Enforcement Officer			

D. PATIENT CONSENT AND AUTHORIZATION FOR EXAMINATION (See instructions)

☐ Law Enforcement Authorized ☐ CPS Authorized ☐ Placed in protective custody ☐ Physician authority pursuant to state law ☐ Parent/Guardian consent

E. DISTRIBUTION OF OES 900 (Check all that apply)

☐ Law Enforcement Agency (original) ☐ Hand Delivered ☐ Mailed ☐ Faxed	☐ Child Protective Services (copy) ☐ Hand Delivered ☐ Mailed ☐ Faxed
☐ Crime Laboratory (copy included with evidence)	☐ Medical Facility Records (copy)

F. PATIENT HISTORY

1. Name of Person(s) Providing History	Relationship to Patient

2. Child Accompanied to Facility By	Relationship to Patient

Patient Identification: **Date:**

3. History of Present Illness ☐ **See dictation for additional information.** ☐ **N/A**

If dictating, provide brief 2-3 sentence handwritten summary. Print or write legibly. Include date, time or timeframe, place of incident, and initial reporting party. Distinguish statements made by child in quotation marks from those statements made by other historians.

G. PAST MEDICAL HISTORY

	Yes	No	Unknown	Describe
Birth History (if applicable)	☐	☐	☐	
Physical Abuse History	☐	☐	☐	
Sexual Abuse History	☐	☐	☐	
Neglect History	☐	☐	☐	
Emotional Abuse History	☐	☐	☐	
Domestic Violence Exposure	☐	☐	☐	
Alcohol/Drug Exposure ☐ Prenatal ☐ Postnatal ☐ Alcohol ☐ Drug	☐	☐	☐	Specify types of drugs if known, and collect urine toxicology up to 96 hours after ingestion:
Hospitalization(s)	☐	☐	☐	
Surgery	☐	☐	☐	
Significant Illness/Injury	☐	☐	☐	
Any pertinent medical condition(s) that may affect the interpretation of findings?	☐	☐	☐	
Allergies	☐	☐	☐	
Medications	☐	☐	☐	
Immunizations Up To Date	☐	☐	☐	
Disabilities	☐	☐	☐	(Specify):
Growth & Development ☐ WNL ☐ ABN ☐ Unknown	☐	☐	☐	

H. REVIEW OF SYSTEMS ☐ Negative except as noted below

☐ See dictation for additional information ☐ N/A

I. NAME OF PERSON TAKING HISTORY (Print Name)	Signature	Telephone	Date

J. GENERAL PHYSICAL EXAMINATION

1. Temperature	Pulse	Respiration	Blood Pressure

2. Height (cm or in)	(%)	Weight (kg or lb)	(%)	Children under 2: (HC)	(%)

3. General physical appearance, demeanor, and level of physical discomfort/pain. Provide brief handwritten summary even if dictating. ☐ See dictation for additional information. ☐ N/A

Patient Identification: **Date:**

4. Record results of physical examination.

	WNL	ABN	Not Examined	See Body Diagram	Describe Abnormal Findings. ☐ N/A ☐ See dictation for additional information
Skin					
Head					
Eyes					
Ears					
Nose					
Mouth/Pharynx					
Teeth					
Neck					
Lungs					
Chest					
Heart					
Abdomen					
Back					
Buttocks					
Extremities					
Neurological					
Genitalia					

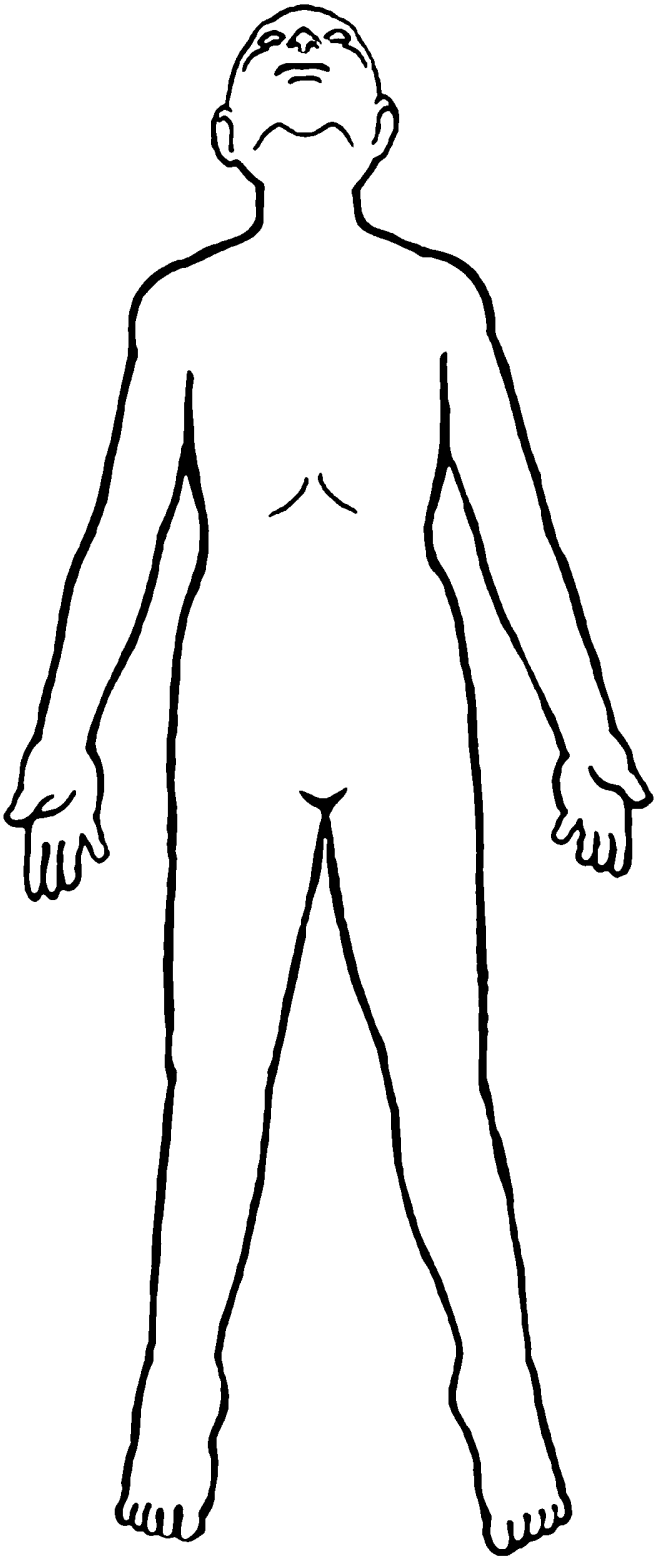
5. If genital injuries are sustained, use copies of page(s) 6 and 7 (if applicable) from OES 930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form or OES 925 Forensic Medical Report: NonAcute (>72 hours) Child/Adolescent Sexual Abuse Examination to document findings and attach to this form.

J. GENERAL PHYSICAL EXAMINATION (continued)

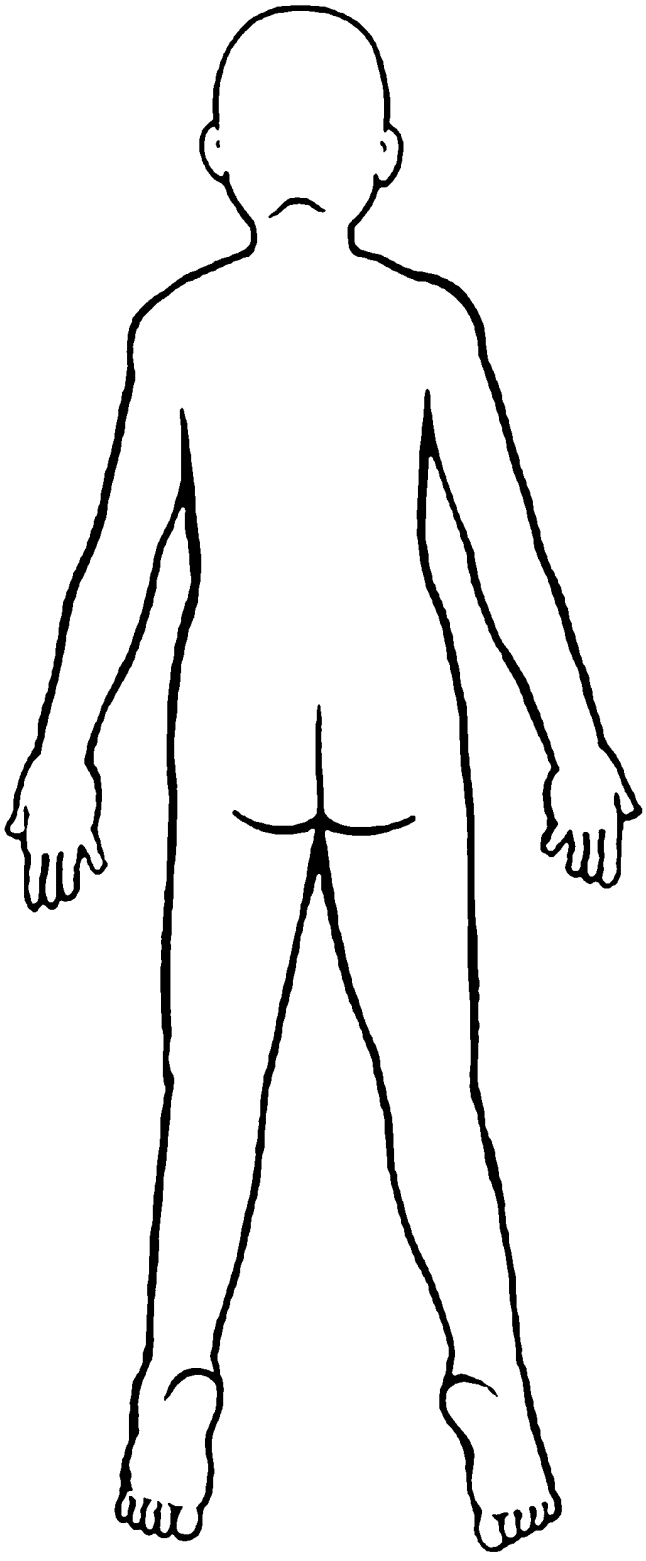
6. Conduct physical examination and record findings using the diagrams.

Patient Identification: **Date:**

A



B

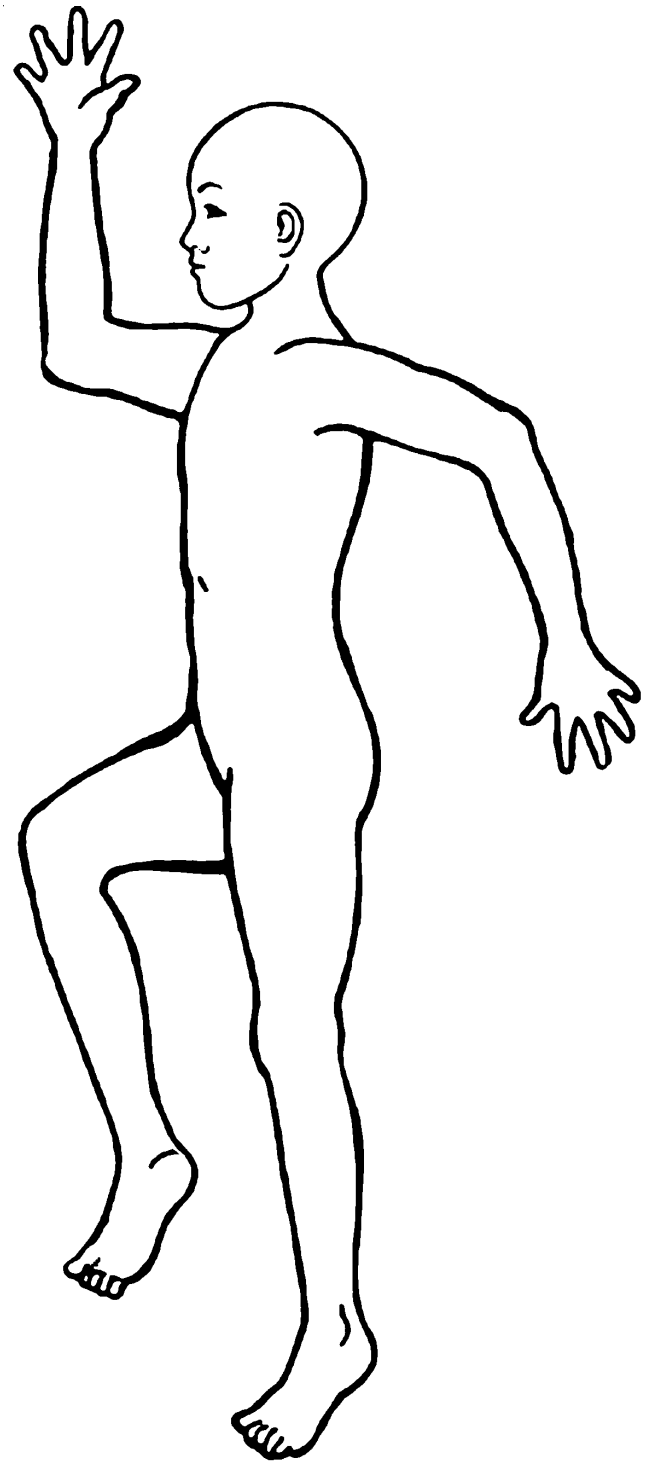


J. GENERAL PHYSICAL EXAMINATION (continued)

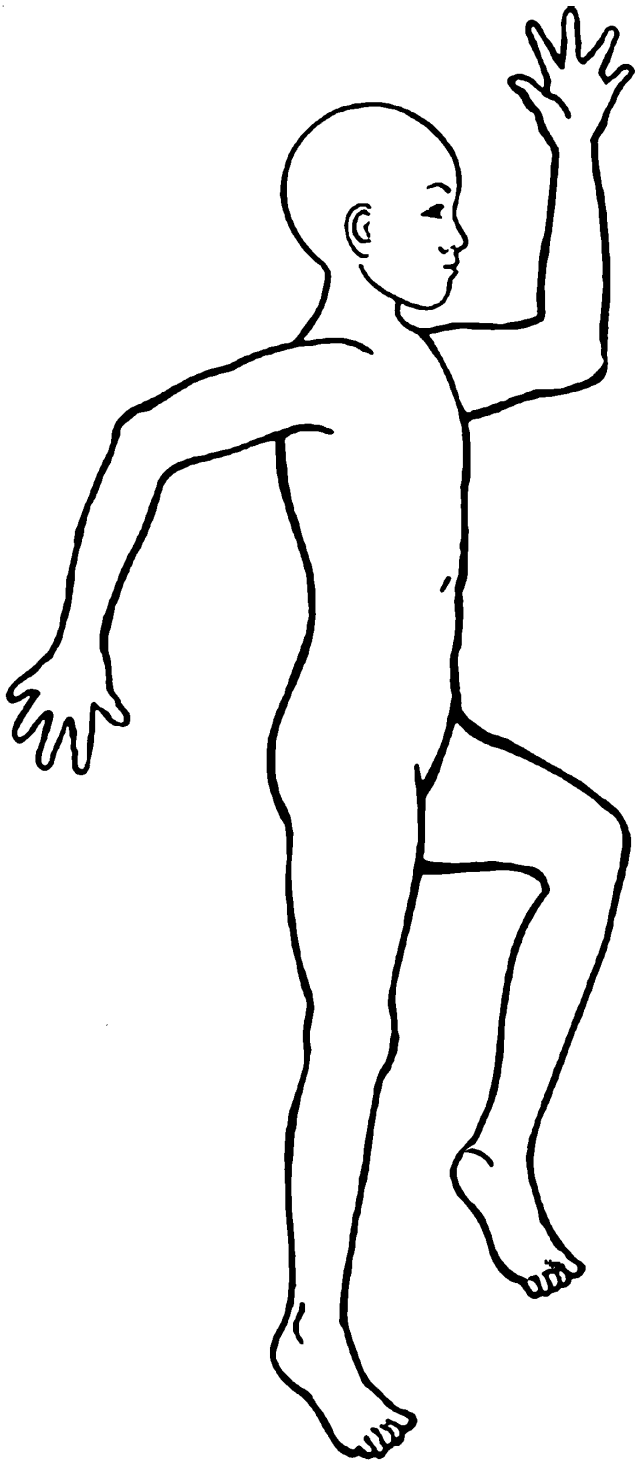
6. Conduct physical examination and record findings using the diagrams.

Patient Identification: **Date:**

C



D

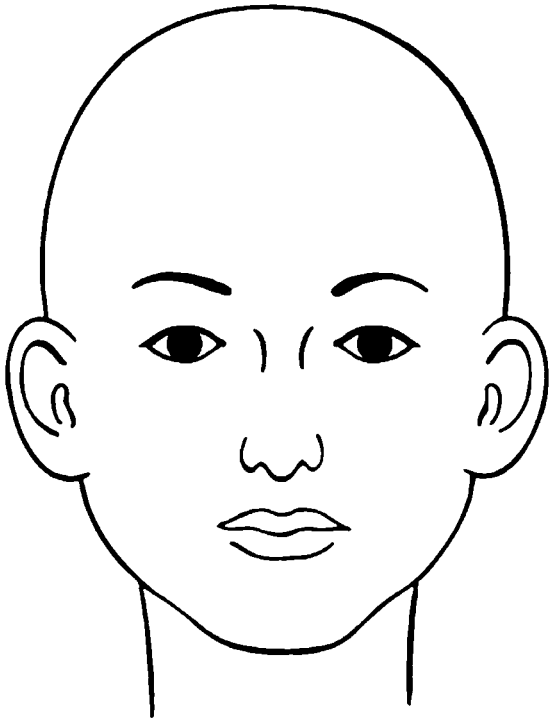


J. GENERAL PHYSICAL EXAMINATION (continued)

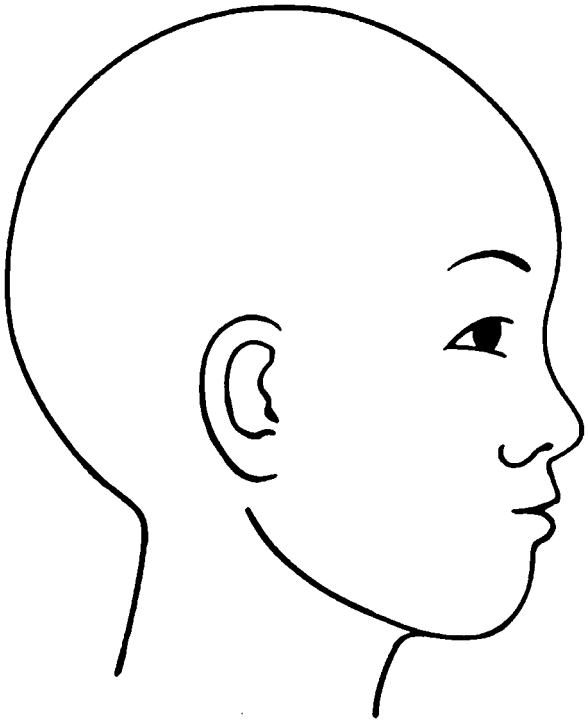
7. Examine the face, head, ears, hair, scalp, neck, and mouth for injury. Record findings using the diagrams.

Patient Identification: **Date:**

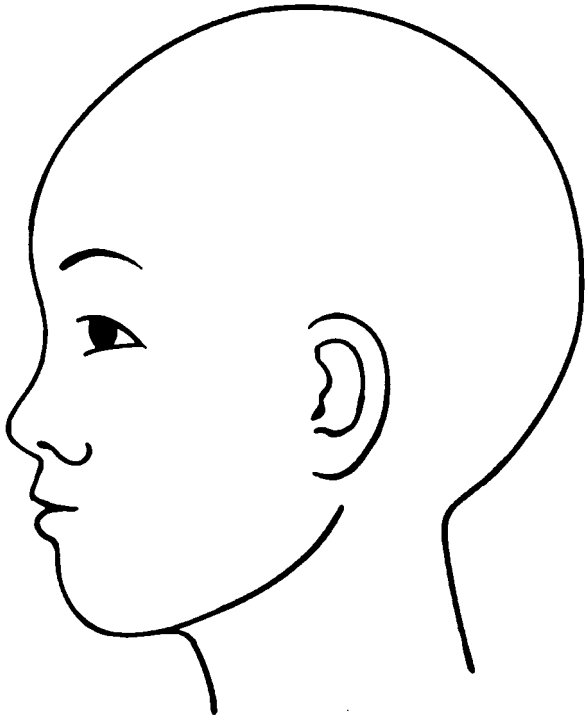
E



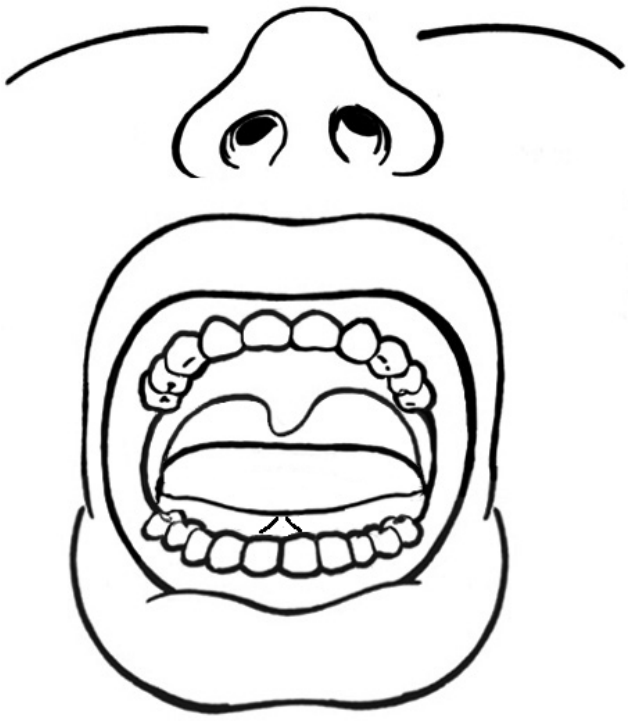
F



G



H



K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing Collected ☐ No ☐ Yes ☐ N/A

Clothing Placed in Evidence Kit	Clothing Placed in Paper Bag

2. Foreign Materials Collected

	N/A	No	Yes	Collected by:
Swabs/suspected blood	☐	☐	☐	
Dried secretions	☐	☐	☐	
Fiber/loose hairs	☐	☐	☐	
Soil/debris/vegetation	☐	☐	☐	
Swabs/suspected saliva	☐	☐	☐	
Foreign body	☐	☐	☐	
Control swabs	☐	☐	☐	
Fingernail scrapings	☐	☐	☐	
Matted hair cuttings	☐	☐	☐	

Other types, describe: _____

L. TOXICOLOGY SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood Alcohol / Toxicology	☐	☐	☐		
Urine Toxicology	☐	☐	☐		

M. REFERENCE SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood (lavender top tube)	☐	☐	☐		
Blood card (optional)	☐	☐	☐		
Buccal swabs (optional)	☐	☐	☐		
Saliva swabs	☐	☐	☐		

N. DIAGNOSTIC STUDIES ☐ Refer to dictation

1. Laboratory:

	WNL	ABN	N/A	Pending	Results
☐ CBC	☐	☐	☐	☐	
☐ Platelets	☐	☐	☐	☐	
☐ INR, PTT, PT	☐	☐	☐	☐	
☐ SGOT, SGPT	☐	☐	☐	☐	
☐ Urinalysis	☐	☐	☐	☐	
☐ Toxicology Screen	☐	☐	☐	☐	
☐ Other	☐	☐	☐	☐	

2. Diagnostic Imaging

	WNL	ABN	N/A	Preliminary Reading	Final Report
☐ Skeletal Survey	☐	☐	☐	☐	☐
☐ CT Scan	☐	☐	☐	☐	☐
☐ M R I	☐	☐	☐	☐	☐
☐ Other	☐	☐	☐	☐	☐

Describe:

3. Exam Performed by Ophthalmologist:

☐ N/A ☐ No ☐ Yes ☐ Pending ☐ See Medical Record for Report

Name of Ophthalmologist: _____

Photographs Taken By: _____

O. PHOTO DOCUMENTATION

☐ No ☐ Yes ☐ N/A ☐ Film Retained

☐ Film Released to: _____

Photographs taken by: _____

35mm ☐ Digital ☐ Instant ☐ Other ☐ _____

Recommend follow-up photographs be taken in 1-2 days

☐ No ☐ Yes ☐ N/A

Patient Identification: **Date:**

P. REQUIRED SUMMARY AND INTERPRETATION OF HISTORY, EXAMINATION, AND DIAGNOSTIC STUDIES

Describe:

☐ Neglect
☐ Physical abuse
☐ Evaluation suspicious for physical abuse. Further information needed.
☐ Indeterminate cause
☐ Evaluation indicates non-abusive cause of medical findings.

☐ See Additional Dictation Dictation Reference Number:

Q. DISTRIBUTION OF EVIDENCE

	Released To
Clothing (items not placed in evidence kit) ☐ N/A	
Evidence Kit ☐ N/A	
Reference samples ☐ N/A	
Toxicology samples ☐ N/A	

R. PERSONNEL INVOLVED

Examination Performed By: (Print)	Signature of Examiner	
License No.	Telephone	Date
Examination Assisted By: (Print)	Signature	
License No.	Telephone	Date
Specimen labeled and sealed by:	Signature	
License No.	Telephone	Date

S. PATIENT DISPOSITION

☐ Admitted ☐ Home ☐ Protective Custody

☐ Follow Up Exam Needed (specify reason): _____